Medicare EMS Group UK Limited

Head Office

Inspection report

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Chelmsford
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Tel:

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Outstanding

Summary of findings

Overall summary

The service was last inspected in 2017 and met the standards required, however we did not have the powers to rate the independent ambulance services. This is the first time we have inspected this location and applied under our new ratings. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Service leaders implemented innovative ways of addressing staffing capacity and skill mix. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well and influenced other providers to improve medicines safety. The service used and developed systems and process to safely prescribe, administer, record, store and audit medicines.
- The service provided mandatory training to staff and made sure everyone completed it. Mandatory training covered a broad range of key skills and the service involved staff in developing the training. The service had established their own training centre which was opening in July 2022 and had already gained accreditation to provide courses for trainee associate ambulance practitioners. The service was proactive in gaining qualified trainers to undertake emergency response (blue light) training. They supported their own staff and external candidates with training courses.
- The service managed safety incidents well and learned lessons from them. It was easy for people to raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service encouraged patients to raise concerns and staff were confident to report all concerns and near misses.
- Staff provided good care and treatment and gave pain relief when they needed it. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Staff had access to useful information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service worked with their commissioners and partner organisations to ensure that services were tailored to meet the needs of the local population. Managers worked well with their partners and influenced changes in clinical practice across the sectors they worked in. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving care continually.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- The service could explore more innovative ways to obtain patient feedback. At present, feedback was obtained online and through paper form, through the commissioners, staff or patients email directly. We did see some positive comments. For those who do not have access to online feedback, alternative ways could be developed to gain a more diverse range of people's voice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good	

Summary of findings

Contents

Summary of this inspection

Background to Head Office

Head Office is operated by Medicare EMS Group UK Limited. It is an independent ambulance service in Chelmsford, Essex. The service provides emergency ambulance transport services to both adult and child patients across England.

The service was established in 2003 providing medical cover and emergency transfers to hospital for large event organisers. As the service developed, the events included, horse racing, concerts, large stadium events and football arenas.

During the COVID-19 pandemic the service diversified to provide support to NHS emergency frontline ambulance services.

The service had developed a training course for trainee associate ambulance practitioners which was ratified and due to commence in September 2022. The service had a purpose build premises with an education facility including a skills laboratory due to be completed and opened in July 2022.

In 2013 the service registered with the Care Quality Commission (CQC) for the regulated activities of:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder, or injury

The main location for the service is in Chelmsford, however they have two satellite locations where vehicles are stationed in Coventry and Hartlepool.

Events are not within our scope of regulation and therefore we do not inspect events. However, at some events, the service provided emergency transport and this falls into our scope of regulation.

In 2019 the service commenced frontline rapid response services crewed by paramedics, emergency medical technicians (EMT) and emergency care support staff (ECA) for the NHS Trust.

The rapid response part of the service developed with the COVID-19 pandemic and the service now has contracts with two NHS Trusts.

During the year 2021, the service carried out the following types of journeys:

- 10,471 total emergency response calls. Of those
  - 6804 patients were taken to the emergency department
  - 2131 patients treated and discharged
  - 1536 patients taken to other sites including cardiac departments, stroke units, major trauma unit, specialist units, mental health units and end of life care.
  - The above number of patients from the emergency response calls included referrals to the patients' GPs, referrals to the falls prevention team and safeguarding alerts to the safeguarding team.
- 86 events per month.

Summary of this inspection

We have inspected Head Office, Medicare EMS Group UK Limited previously in December 2017. At that time, we regulated independent ambulance services but did not have the legal duty to rate them. Good practice and areas for improvement were highlighted.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The medicine management system had been designed by the chief executive officer (CEO) and the registered manager and provided a robust system for prescribing, storing, administration and disposal of medicines. The processes in place specifically addressed and mitigated the risk of human error in the management of medicines. The service had worked with partner organisations to share these systems and to influence and improve safe working practices both in the private and public sector.
- The service had established an accredited training academy for fully funded associate ambulance practitioner apprenticeships with the first intake due in September 2022. We saw this programme had already been accredited. The provider had offered additional places to NHS partner organisations to address the staffing and skills deficit in the sector, whilst fostering partnership working amongst staff from all organisations.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve

- The service could explore more innovative ways to obtain patient feedback. At present, feedback is obtained online and through paper form, through the commissioners, staff or patients email directly. We did see some positive comments. For those who do not have access to online feedback, alternative ways could be developed to gain a more diverse range of people's voice.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Outstanding	Good
Overall	Good	Good	Good	Good	Outstanding	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding

Are Emergency and urgent care safe?

Good

We rated safe as good.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it. In addition to mandatory training, services leaders proactively identified innovative ways of upskilling staff within their own service and within other local services.

Staff had received and kept up to date with their mandatory training which included moving and handling (M&H), infection prevention and control (IPC) and life support training. Although staff worked for the service on a flexible zero-hours contract, they all followed the service's mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Training was a combination of online and face to face for practical aspects. Inhouse training sessions were conducted with specific topics relating to the service, for example head injuries, major trauma and frontline staff induction course relating to the expectations of the two different NHS Trusts. The course training material viewed was comprehensive and in-depth. Staff attended courses to support their continued registration with the Health and Care Professions Council (HCPC). All clinicians (paramedics, emergency medical technicians and emergency care assistants) were appropriately trained for emergency response driving (blue light). We viewed evidence of accredited driving courses in staff files.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia. Part of the commissioning contract for paramedics to retain their registration with the National Health Service (NHS) was the completion of mandatory training annually. The NHS Trust followed safer recruitment practice checks monthly to ensure all aspects of staff employment requirements were current.

Managers monitored mandatory training completion and alerted staff when they needed to update their training. The service had changed their training provider and their process assisted the registered manager to monitor training with alerts. We viewed the training matrix and noted 92.5% of clinical staff had completed their mandatory training with only three staff outstanding in one subject. Training data showed 100% of paramedics had completed their training. Paramedics told us they received advanced life support (ALS) refresher training every six months.

Good

Emergency and urgent care

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The service had comprehensive adult and children and young people safeguarding and whistleblowing policies and procedures which staff had access to electronically. The policies outlined clear staff roles and responsibilities relating to reporting of concerns and considered current best practice. There were clearly defined and embedded systems, process, and standard operating processes in place to keep people safe.

Training data showed 100% of clinical staff had received training to level 3 for safeguarding adults and children and we found evidence in the matrix, certificates in staff files and from speaking with staff. The safeguarding lead was undertaking level 4 Children and Young People and Adult Safeguarding training. This was in line with national guidance of the intercollegiate documents for both Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019).

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were proactive in reporting concerns and the registered manager told us staff had highlighted a rise in patients having specific safeguarding concerns because of COVID-19 pandemic restrictions. These had now been incorporated into the safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had contracts with two NHS Trusts and safeguarding referrals were made through the referral system at each Trust. From January to December 2021, the service had made 167 safeguarding referrals which demonstrated staff recognised people at risk of abuse and reported it appropriately. Safeguarding audits were conducted daily to ensure all concerns had been forwarded to the local authority.

Managers had worked with NHS partner organisations to improve the timeliness of referrals where staff identified welfare interventions were needed. The service had identified issues with welfare referrals, the paper referrals were only being processed on a weekly basis which meant there was a delay and were treated differently to the electronic safeguarding reporting. The service raised this with their partner organisation and all referrals were made electronically to ensure patients received timely support. The service monitored the outcome of the change monthly and noticed an increase in referrals in a more timely manner.

The service followed a robust recruitment process and completed employment checks to ensure staff recruited were safe to care for adults and children. An application form was completed and references of last employment, right to work in the UK and photographic identification was obtained. All newly recruited staff had an advanced Disclosure and Barring Service (DBS) check completed before commencing employment. Staff signed up to the DBS update service to enable the service to check DBS records annually to ensure they remained current. The DBS is a national agency that holds information about criminal records. The employment checks were compliant with Schedule 3 of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment, vehicles, and the premises visibly clean.

Good

Emergency and urgent care

The service had a COVID-19 pandemic protocol for visitors which included asking declaration health questions relating to the virus. Visitors had their temperature taken to detect any signs of illness and were asked to use the available hand gel. People were asked to wear a facemask (except for those medically exempt) and facemasks were available.

All areas of the service were visibly clean and had suitable furnishings which were clean and well-maintained. We observed a clean working environment.

The service consistently performed well for cleanliness. We reviewed documentation which included hand hygiene audits with clinical staff which showed 100% compliancy. Regular IPC audits were undertaken on different areas of the building and showed compliancy.

Staff consistently followed infection control principles including the use of personal protective equipment (PPE). There was enough PPE available both in the ambulance station and ambulance vehicles for crew access. The service provided staff with a uniform, and we observed staff were smartly dressed wearing the appropriate uniform, shoes and any long hair was tied back.

Staff cleaned equipment after patient contact. Staff undertook daily internal cleaning of the vehicles before leaving the service. Body fluid spillage kits were available for use, and cleaning agents for staff to clean their vehicle at the provider stations after a call had been completed. We observed staff checking their vehicles diligently before commencing their shift, ensuring they were visibly clean, and equipment and sterile items, were stored correctly. Staff told us it was their personal and professional responsibility to ensure their vehicle was ready for deployment.

Cleaning records were up to date and consistently demonstrated that all areas were cleaned regularly. The service had a six-week vehicle deep cleaning procedure, and we observed some vehicles going through the deep cleaning process at the time of inspection. Windscreen notices were on each vehicle stating when they were next due a deep clean. The registered manager told us they had recently changed their external deep cleaning provider. The registered manager noticed the deep cleaning provider was undertaking adenosine triphosphate (ATP) swabbing and the standards percentage was deteriorating, and no action was taken by the cleaning provider. ATP testing is a process of quickly measuring actively growing micro-organisms. The registered manager diligently monitored the results and due to the continued lower percentage records, the service then changed cleaning providers. From the quality reports, swabbing standards had improved under the new provider.

The service had been pivotal in developing safe COVID-19 protocols for the reintroduction of horse racing following the lockdown. Managers had reviewed national policies and guidance to ensure staff were compliant with PPE requirements in a timely way in the event of a major trauma during an event where conveyance to hospital may be required because of critical injury.

We viewed deep cleaning records for four vehicles which included photographs of the vehicle and an itemised list of ATP swabbing results. The record included the condition of the exterior of the vehicle and for any internal wear and tear, documented in a comprehensive report.

The garage cleaning station followed the national infection prevention and control (IPC) guidance for colour coding of cleaning items, for example yellow coloured mop heads and buckets for ambulance interiors, which were stored separately.

Regular COVID-19 IPC audits were completed, and actions taken as required to ensure the service remained IPC compliant and in line with national policy.

There was a wash station with a large stainless steel sink with hot and cold water and filtered sluice. Cleaning items including clinical wipes and paper towels were contained safely within a rack. There was a cleaning solution storage cupboard with information relating to control of substances hazardous to health (COSHH).

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service was over two floors with the entrance door which was keypad protected. Upstairs there were offices where the administration was conducted. Downstairs was a meeting room, staff kitchen and various store areas including a medicine storage room.

The corridor led from the office area into the secure ambulance station where ambulance vehicles were garaged with clearly marked ambulance bays and walkways. Fire doors separated the areas for safety. The service had closed-circuit television (CCTV) as part of their security system and there were information notices displayed on walls in line with legislation.

When vehicles returned to the service at the end of the shift they went through the 'make ready' system. Two staff (make ready operatives), ensured the vehicles were restocked, clean and ready for deployment. Any shortfalls or mechanical defects were reported and addressed. The next ambulance crew taking out the vehicle then carried out their daily safety checks of specialist equipment. The service had a positive safety culture in relation to care practices and vehicle maintenance.

We observed staff who had arrived prior to their shift checking their vehicle before leaving the station using a stock checklist. Staff carried out daily safety checks of specialist equipment both inside and outside the vehicle. We checked equipment including oxygen cylinders for level of oxygen, automated external defibrillators (AED) which had been calibrated and were in good working order, maternity pack, suction, and paediatric equipment. All items were up to date with servicing, functional and stored securely.

Staff checked each piece of equipment to ensure it was working correctly. They documented on their checklist the outcome of each check. The record was then scanned, and data stored. The faulty equipment was logged as an incident, removed, tagged as faulty and a replacement was found. The clinical managers who had oversight of the checking procedures were informed of any faulty equipment and replacements. We saw records of actions taken when defects were recorded and when they were resolved.

We viewed electrical testing certificate where all portable appliance testing (PAT) had been completed and was in date. Audits were undertaken of the environment including the garage area which looked at security and that pedestrian walkways were free of trip hazards. Audits viewed showed compliance. Medical equipment had been serviced and calibrated by the appropriate service provider.

The service had enough suitable equipment to help them to safely care for patients including specialist equipment when in attendance at events. The service had dedicated equipment to care for horse racing related injuries and staff had received specialised training. Equipment was available to secure patients safely while in transit and we saw safety belts for adults and safety harnesses for children.

Equipment was stored in the garage in secured racks within large labelled transparent containers for restocking vehicles at the end of shifts.

We viewed the vehicle fleet safety and service record which recorded MOT tests where applicable and service history and found these to be current. Faulty vehicles were effectively managed, and we viewed records relating to repairs including the vehicle repair log and garage invoices demonstrating repairs had been carried out.

All vehicles were owned by Medicare EMS Group and had the appropriate insurance. Staff told us the vehicles were in an excellent condition. We viewed three vehicles that had been checked and viewed externally including lights and internal cleanliness, we found all to be fully functioning and ready for deployment.

Staff disposed of clinical waste safely. The service had a clinical waste guidance with clear instructions on how to dispose of all aspects of clinical waste including how to transport clinical waste safely within the vehicles. We viewed the sharps bins and they had been signed and dated in line with regulation. General and clinical audits were completed daily identifying the serial number for the clinical waste container. We saw that the clinical waste audits showed compliancy.

Fire safety checks were conducted on the building and the garage area which included correct signage, fire door and detection system and fire extinguishers. Each vehicle carried fire extinguishers and we saw these were checked and secured safely.

Assessing and responding to patient risk

The service embedded a safety culture within their organisation and ensured patient risks were assessed and responded to appropriately. Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The service provided emergency and urgent care at horse racing and arena events. The service had influenced safety at major sporting events with the introduction of the use of trauma networks. The service had driven change and improvement within the horse racing industry to ensure that jockeys following a major trauma, were transported to the regional trauma centre to ensure they were treated at the right time in the right hospital.

Specialist risk assessment were required when in attendance of some events, for example horse racing and large arena events. The registered manager explained how they were venue-led when they assessed the event to ascertain the staffing and equipment requirement. For example, for some events required a large number of staff of different designations including managers for leadership. The service managed risks positively and had provided attendance at horse racing events for over 10 years and the registered manager told us there were strict protocols and high standards they had to maintain to ensure continued commissioning.

Staff received training on conducting risk assessments for emergency response calls and events. They received specific training relating to risk assessments for each type of activity staff would be undertaking both frontline and for different events and had been risk assessed using the RAG (red-amber-green) rating.

Staff completed regular simulation training which included, for example, major trauma assessment and specialist splint applications and cardiac arrest. This training was completed by teams as scenarios with a supervising assessor. Staff received feedback in relation to these scenarios and learning was shared across teams.

Staff completed risk assessments for each patient on arrival, using a comprehensive tool and reviewed this regularly during the journey. All clinicians had completed the National Early Warning Score (NEWS) 2 training. Staff used a Systems Assessment Tool, which included for example, the sepsis screening tool, to assess the patient's condition and

to identify deteriorating patients and escalated them appropriately. Staff knew about and dealt with any specific risks. The service had in place clear pathways for patients and staff knew about and dealt with different specific risk issues. Staff took a proactive approach to anticipating and managing risks to ensure patients received the appropriate care. Patients with certain diagnosis such as those suffering from a heart attack or stroke would be taken to the appropriate unit.

The service provided guidance for staff on management of critical conditions such as heart attacks, stroke and sepsis through regular clinical update protocols identified as Care Bundles (specific interventions). The information provided staff with recognised guidance on signs and symptoms, observations and actions including the deteriorating patient. For example, the sepsis care bundle provided guidelines in line with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Crews communicated with on call professionals for advice and support when they attended the patient's home and had access to a registered mental health nurse and doctor.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff had access to professionals to gain advice and to establish if the patient had a previous history of mental health issues.

Staff received regular clinical updates relating to care bundles for a range of medical conditions which gave clear guidelines for staff to provide consistent and evidenced based care. This ensured staff clinical practice remained current. This included a comprehensive sepsis detection and management bundle.

Staff told us they were confident to call for assistance if it was required. The registered manager told us they had an effective on call system to support staff. There was a clinical line the crew could call to speak with appropriately qualified staff including paramedics, registered mental health nurse, registered general nurse, doctor or senior paramedic.

Staff shared key information to keep patients safe when handing over their care to others. The registered manager showed us some complimentary correspondence where nursing staff had thanked the crew following handover for their knowledge when caring for a patient.

The service had developed a protocol for the assessment of a person who was disorientated. This protocol was designed to rule out a head injury, diabetes or drug or alcohol induced confusion.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service had developed an apprenticeship programme to address staff shortages within the wider health and care system.

The provider had plans to open a training academy in July 2022. The service planned to provide fully funded associate ambulance practitioner training through their accredited course. We were told there were proposals to offer training courses to other providers.

The service had plans to move to new premises to accommodate their new academy in July 2022. In addition, plans were underway to permanently employ staff to further assist NHS partner organisations and to meet the needs of their local population.

The management team and administration staff were employed by the organisation. Clinical staff including paramedics, emergency medical technicians (EMT) and emergency care support (ECA) staff were self-employed. All staff employed were qualified and experienced.

The service had enough staff to keep patients safe. They were allocated specific shift times and were available 24 hours a day, seven days a week.

All clinicians were registered with the NHS Trusts to facilitate people on vehicles and when compliant with their training they were given a personal identification number (PIN) with the Trust. Part of the ongoing employment process was to ensure clinicians were registered with the Health and Care Professions Council (HCPC). We reviewed six staff recruitment and training records which had all been completed correctly and were up to date.

Managers accurately calculated and reviewed the number and grades of clinical staff needed for each shift in accordance with national guidance and commissioning contracts. The registered manager explained that staffing numbers and skill mix were dependent on the care provision, for example NHS Trust frontline staff, horse racing event attendance or large arena events. Planning for staffing levels also included management and leadership teams that would be required for some large events.

Managers could adjust staffing levels daily according to the needs of patients. There was a rostering system which staff had access to where they could provide their availability and where available shifts were outlined. Staff told us they put their availability on the system and then they received email notification of the shift they have been assigned to, and then accepted or declined. There was flexibility in shift reallocation if required.

The registered manager told us there were plans to move to a new premise and they would then be employing permanent clinical staff as part of the company development and new commissioning contracts.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The service followed a data management process to ensure records were kept securely and staff could access them easily. Staff completed a comprehensive patient record form (PRF) assessment sheet for each patient which included personal details, mental capacity, communication, initial observations, and a list of any medicines the patient was taking if appropriate. The service had additional forms for recording capacity assessment, consent to treatment and refusal of treatment. The service provided staff with additional screening tools, for example safeguarding information guide, to assist decision making. Both electronic and paper copies were available to staff. Any specific areas of concern or referrals made to other services such as social services were documented. Sections of the form related to the monitoring of the patient's condition including a body map, and the crew documented any treatment, observations and medicines administered.

When patients were transferred to the hospital team, there were no delays in staff accessing their records. A comprehensive handover of the history and actions the staff had taken, including medicines administered, was cascaded to the hospital staff. A copy of the PRF was given to the hospital staff for their records.

When the handover was completed, the copy of the PRF was placed in an envelope and sealed. No personal details were written on the front of the envelope. The envelope was then stored securely in a section of the vehicle and upon reaching the service was placed in a locked post box in the office.

The registered manager reviewed each PRF every day and appraised the contents to ensure they were completed correctly and accurately. If the form had not been completed fully or correctly, the registered manager told us they would speak to the completing staff member for future learning either directly or through supervision. Areas of excellent practice were also acknowledged through emails to the staff member. Staff had their own login to access the system to enable them to review their feedback from the PRF audit.

The electronic auditing system for the PRFs presented a number of pre-determined questions for patient symptoms, for example for stroke, that staff answered to ensure the care provided to the patient was appropriate for their presenting complaint in accordance with best practice.

The PRF was scanned and retained in the secure computerised system. The PRFs we reviewed on the computer were clear and fully completed. Staff told us they were positive about the registered manager checking each PRF and provided constructive feedback for improvement if required, which they appreciated as a learning opportunity.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. The service influenced medicines safety in partner NHS organisations.

Staff followed systems and processes to prescribe and administer medicines safely. The service had an effective electronic medicine management system which had been designed by the registered manager and the chief executive officer (CEO). The system identified a dashboard of all the medicines in stock and each of the medicine bags. Stock management identified the medicine, dose, batch number, expiry date and quantity and where the medicine was stored. The registered manager told us the system was comprehensive and reduced risks through identifying early when medicines were reaching their expiry date, thereby reducing waste, and stock control ensuring there was always enough supply.

Staff completed medicines records accurately and kept them up to date. Any medicine given was documented on the PRF and on a separate medicine used form, both of which were checked by the compliance administrator during their daily audit. The medicine system tracked medicines from the point of entry to the point the medicine was administered to the patient or disposed of correctly by the company. The system also identified if a medicine was missing but had not been administered to a patient or correctly disposed of.

The service had a comprehensive medicine management policy and guidelines which included controlled drug management. Medicines were reviewed by the compliance administrator to update the electronic medicine management system daily to ensure compliance with medicines policy and procedure. When medicine bags were stocked, they were sealed and stored in the medicine room for immediate use. The electronic medicine management system identified each medicine in the bags including batch number and expiry date. Clinicians signed out for the medicine bags and signed in on return and the bag was placed in a separate container for restocking. The compliance administrator checked the bags against the medicines used form and replaced stock as required. This was documented on the electronic medicine management system.

Good

Emergency and urgent care

Medicines were stored in a dedicated locked room. Medicine stocks were in a key fob secure storage unit with controlled drugs (CDs) stored separately. The temperature of the room was recorded, and we noted that it was within the recommended range. The registered manager told us they had systems in place with heating and cooling equipment to ensure the room temperature remained within range if required in adverse weather conditions which could cause fluctuations in room temperature.

We checked a sample of paramedic medicine bags and verified stock quantities, drug batch numbers and expiry dates. We checked the stock medicines including controlled drugs and they tallied with the electronic medicine management system, being 100% correct. Each medicine we checked was documented clearly on the dashboard including batch numbers, expiry dates and the amount of stock left. There were colour coded control measures on the dashboard highlighting when stock had reached the pre-determined minimum stock level.

Stocked medicine bags containing the appropriate medicines were colour coded to ensure safety and ease of identification for example, blue paramedic bag, red cardiac bag, yellow technicians' bag. Medicines listed by the Medicines and Healthcare products Regulatory Agency (MHRA) for paramedic use and by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) were obtained and stored on site.

The service had a doctor and pharmacist who had oversight of the prescribing, ordering, and storing of medicines. There was a separate CD policy and guidelines highlighting different staff level responsibilities. The service was registered with the Home Office to prescribe CDs and were managed in line with government legislation. We viewed controlled drug weekly audits and found them to be in order with no errors. All medicine audits we viewed showed no errors.

To enable medicines to be given safely by the appropriate staff member in line with the legislation, Patient Group Directions (PGD) were completed by the doctor and pharmacist and signed by each staff member. The service had a clear legal framework for medicine administration for the use of Patient Group Directions.

The service had worked with other organisations to improve practice in the storage and management of controlled drugs. The service had worked with the chief medical officer for horse racing to ensure best practice. Patient group directives (PGD) were in place and followed across the industry. Medical gases were stored safely within the garage area in a metal cage which was locked and fixed to the rear wall.

Staff stored and managed all medicines and prescribing documents safely. Medicines stored in the vehicles were in a locked cupboard. Only paramedics had access to CD drugs, and they were stored securely on their person.

Any incident or discrepancy would be reported as an incident. There had been no incidents since the new system had been in place. The registered manager was extremely proud of the medicine management system which they found easy to use and effective.

Staff learned from safety alerts and incidents to improve practice. To ensure continued safe administration the service had protocols on the administration of specific medicines which provided staff with clear guidance on how and who was permitted to administer each medicine. Any updates about medicines in line with legislation by the medicine and healthcare products regulations agency (MHRA) were forwarded to staff to ensure continued current practice.

Good

Emergency and urgent care

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The provider had an incident reporting policy which identified definitions of different incidents and detailed the procedure of reporting, recording and investigation including Reporting of Injuries, Disease and Dangerous Occurrences Regulations (RIDDOR) 2013. The policy outlined the roles and responsibilities of staff and management, and duty of candour.

Staff received training in incident management and knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider policy. There was an open culture where staff were confident to raise any safety concerns, and their concerns and ideas were listened to and valued.

The service had no Never Events. From February 2021 to February 2022 no Never Events had occurred in the service.

The policy included guidance on completing the electronic Incident Report form within 24 hours of the incident occurring. If the member of staff was unable to complete for any reason, the operational manager would complete the form on their behalf. The electronic form would automatically be sent to the Executive Leadership Team.

Staff reported serious incidents clearly and in line with NHS Trust policy for the third-party commissioning contract. The service had commissioning contracts with two NHS Trusts and reported incidents through the national reporting and learning system (NRLS).

The quality of incident reporting showed the process was robust. The safety culture and effective systems in place reduced the risk of incidents, and when an incident did occur, the electronic system allowed for it to be reported by the staff member and reviewed by senior personnel within a brief period and action taken.

Managers investigated incidents thoroughly. The incident policy referred to patient and family involvement in investigations.

Managers debriefed and supported staff after any serious incident. Managers shared any recommended learning with their staff. Staff received feedback from investigations of incidents, both internal and external to the service. A monthly audit was completed, and any learning shared. The registered manager gave an example of an incident where someone collided with their stationary vehicle. The incident was followed through and reviewed by the registered manager.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

There was evidence that changes had been made as a result of feedback. For example, staff reported to the registered manager they were concerned about the increase in patient mental health and self-neglect issues as a result of COVID-19 pandemic restrictions. The registered manager used this as a learning exercise for staff to ensure they received additional training on managing stressful situations as a result of the COVID-19 pandemic restrictions.

Good

Emergency and urgent care

Staff met to discuss the feedback and look at improvements to patient care. Safety review meetings were held weekly and included frontline operations and racing and events attendances.

Managers reviewed learning following incidents and engaged with other providers to strengthen their own processes. The registered manager told us the service kept up to date with inquiries commissioned following major incidents to ensure they were able to implement learning at the earliest opportunity.

Are Emergency and urgent care effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Standard operating procedures reflected relevant legislation, for example, the clinical waste policy referred to the Controlled Waste Regulations and the administration of Ipratropium Bromide protocol followed the guidance in accordance with the JRCALC guidelines. Staff had electronic access to policies which they could refer to at any time. Policies were version controlled which ensured staff had access to the most recent version.

Staff took a holistic approach to assessing and delivering care to ensure the patient received the most appropriate care. Staff adhered to protocols for specific critical conditions. The nationally set care bundle guidelines referred to expediting the patient to medical care through the most appropriate pathway. Each NHS Trust had their own escalation pathway. The crew had access to professionals to discuss the patient's condition to assess the most appropriate pathway. The care bundles were reviewed regularly and staff received written updates to ensure consistency of care and current practice.

The service incorporated training for staff on care bundle care delivery to ensure consistency and compliance across NHS and event contracts. The service reviewed the outcome of care bundle compliance in their monthly executive leadership team meetings. They undertook and end-to-end audit from November 2020 to November 2021 which showed compliance and improvement in patient care, for example, return of spontaneous circulation (ROSC) compliance from 50% 2020 to 83% compliance 2021.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff understood mental health conditions and had highlighted an increase in incidents, particularly related to patient self-neglect during the COVID-19 pandemic. Staff had access to the clinical line to enable them to communicate with a registered mental health nurse for advice, which provided staff with support to meet the standards of the MHA Code of Practice to achieve the best outcomes for the patient.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Where additional assistance was needed before the patient could be taken to hospital, for example pets, vulnerable adults or children that may be at the patient's home, the staff told us they were confident to call the relevant professional.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice if it was appropriate to do so. Staff completed two pain scores, before and after treatment, to evidence they were effectively managing the patient's pain. Part of staff supervision related to the administration of medicines and knowledge around care bundle medicine to ensure staff were competent to deliver pain relief relevant within their designation scope. We noted from one supervision record the administration of cardiac care bundle medicines was discussed.

Patients received pain relief soon after it was identified they needed it and staff prescribed, administered, and recorded pain relief accurately. The service had produced an in-depth clinical guidance for staff on pain management procedure which was easy to follow. Staff were familiar with the mental capacity act and where necessary made best interest decisions. The staff had communication access to other professionals and were able to seek advice when required. Pain relief medicines were documented in the patient's PRF and were reviewed by the registered manager as part of the auditing process.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. We reviewed the monthly audits which included safeguarding referrals, medicines, and falls. The service was aware of health promotion and prevention of ill-health and referred patients to the appropriate professional including the GP, diabetic team, end of life referral and the falls prevention team.

The service benchmarked themselves against the national NHS ambulance services quality inidicators for clinical audits for sepsis, return of spontaneous circulation (ROSC), ST-elevation myocardial infarction (STEMI) and strokes to ensure that the care provided by the service was comparable with the NHS. The statistics showed the service to be in line with NHS ambulance services.

The registered manager told us they received compliments from patients, their relatives and health professionals. We viewed some of the comments from patients and relatives which read, "The crew turned up within minutes, were calm collected and even made us laugh, I am so grateful for all your hard work," and, "Staff were very professional, informative and friendly in what was a very worrying situation for us, thank you."

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The head of compliance reviewed the outcomes of the audits. The registered manager had oversight of all the audits, and they were discussed at management meetings. Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. The service had been open and transparent about the outcome of audits and had set up a large notice board which contained the outcome of audits for staff to read.

Improvement was checked and monitored and discussed at the relevant management meetings. Part of the compliance with the Major Trauma Tool was to review all horse racing incidents to the racing division of the service who raised these at the Safety Review Meeting to discuss those patients who had been conveyed to the major trauma centre. We viewed minutes of meetings which analysed the individual cases and the paramedics response to the major trauma, and the appropriateness of the referral, for example to the major trauma centre or general hospital. Lessons learned were shared with staff.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. We reviewed staff training files and found staff had attended accredited courses of theory and practice for emergency response driving (blue light) training. The registered manager told us they only recruited qualified and experienced staff. Clinical staff registration with the Health and Care Professions Council (HCPC) was checked and staff were assisted to maintain their registration through continued professional development.

Although staff were self-employed on zero-hour contracts, the service conducted a robust recruitment process including obtaining application form, references, right to work and DBS checks. They obtained a medical history which included ensuring staff had received their necessary recommended vaccinations for their role. Certified copy of driving licence was obtained from staff members and confirmation checks were made with the Driver and Vehicle Licensing Agency (DVLA) to confirm legitimacy of licence.

Managers gave all newly recruited staff a full induction tailored to their role before they started work. Newly qualified paramedic staff followed the service's Newly Qualified Paramedic (NQP) support programme, which covered 150 hours of supervised practice with an experienced paramedic and the completion of the NQP consolidation record book. The clinical managers supervised their practice and monitored progress. If further support was required, this was arranged. Staff told us they appreciated the support from the experienced paramedic and the clinical managers.

Care bundle training was part of the induction, which provided staff with comprehensive knowledge around focused interventions ensuring consistency of care in line with NHS procedures as part of improving patient outcomes. Staff had access to regular updates to ensure practice remained current.

The service did not conduct annual appraisals for clinical staff as they were self-employed on zero-hour contracts, however managers supported staff to develop through regular, constructive clinical supervision of their work. The service had a clinical supervision policy which included guidelines on clinical supervisions and adverse events. A set supervision form was used to ensure consistency of supervision standard questions and clinical observations. Managers supported staff to develop through regular supervisions which were held every four to six weeks and included observation of practice to ensure continued compliance. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve.

The clinical educators supported the learning and development needs of staff. Staff told us they were supported for personal development and that the registered manager was approachable and knowledgeable.

Staff completed regular simulation training for major trauma and critical illness such as cardiac arrest. Clinical educators provided supportive and constructive feedback to staff about the completed simulations. The registered manager told us the service provided training for frontline paramedics and clinical managers in the use of the Lund University Cardiopulmonary Assist System (LUCAS). LUCAS is a mechanical chest compression device which is used to maintain effective chest compressions during a cardiac arrest and removes the risk of rescuer fatigue leading to inadequate compression depth and rate.

Ongoing training and opportunities were available for staff. Staff told us they were encouraged and supported in their personal development. They said they enjoyed the flexibility of the work as it enabled them to study for higher education and achieve a good work life balance.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had developed their own training centre accredited with a recognised education provider and were approved for the apprenticeship scheme for ambulance staff to commence in September 2022. Managers told us they planned to fully fund training for their own staff to complete the associate ambulance practitioner apprenticeship. Staff employed in this capacity were planned to train alongside staff from partner organisations including from the NHS. Managers expressed the aim was to foster partnership working at the beginning of a person's training in the sector.

Managers told us the service was able to employ staff that did not hold a emergency response driving qualification as they were able to offer this training in house. They had four qualified driver trainers to provide emergency response (blue light) training and ongoing compliance assessments. The service also offered training to other ambulance providers both in the public and private sector. The registered manager told us they have been able to provide training to 48 ambulance clinicians across the country working for both public and private sector, increasing the number of available clinicians with emergency driving skills.

Managers ensured staff received any specialist training for their role, for example conflict management and breakaway training. Staff received supervisions and competency observations to ensure their skills and knowledge remained current. Procedure information for management of serious incident policy, management of shock and major haemorrhage procedure were available for staff as guidance to ensure consistency of practice.

Managers identified poor staff performance promptly and supported staff to improve. For example, staff told us they appreciated the registered manager checking their PRF and for providing constructive criticism which resulted in improved PRF recording.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients such as the mental health team and on some occasions the police.

Good

Emergency and urgent care

The service worked closely with their commissioners, which included events organisations and NHS Trusts to agreed service standards, protocols, and procedures. This included maintaining staff training, competencies, and uniform requirements. Staff completed the handover process in line with agreed contracts from crew to nursing and medical staff at hospitals on arrival which included providing the hospital with a copy of the PRF.

Management held regular and effective multidisciplinary meetings to discuss service performance and improve care. The service worked closely with social services and health professionals and there was a clear line of communication for staff to contact when they were in patient attendance. The service had been influencial in approaching patient welfare concerns. Staff were actively engaged in monitoring and improving care outcomes and reported an increase in welfare concerns. It was noted there was a delay in referrals to the appropriate social care service due to the paper-based process used by the Trust. After consultation with the Trust, the paper referrals were changed to electronic thereby improving the referral times which had a positive impact on patient care.

The service had contracts with two NHS Trusts and staff were provided with guidance on the differences in procedures including Trust audits on how the PRFs were completed. The service informed staff of any comments from the audits as a lesson learned for improved patient care.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The service had a structured policy on consent and mental capacity. This provided staff with guidance on mental capacity, gaining informed consent and best interest decisions in critical life-threatening situations. The service provided additional clinical update guidance for staff in relation to MCA and COVID-19.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There was a section on the PRF for the patient's mental capacity to be recorded. The registered manager reviewed and audited every PRF daily and monitored consent recording. The service had a designated audit for mental health presentations which included risk assessments, suicide risk assessment and if restraint was required if it was proportionate and in accordance with the provisions of the MCA. The service was actively reviewing ways to improve how people were involved in making a decision, including using the most appropriate means such as the multi-language books available to staff.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and this was documented on the PRF and the separate records relating to consent and mental capacity. Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. For example, staff used communication aids to establish understanding.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. The safeguarding children policy recognised children and young people and provided guidance for staff treating this group of people.

Good

Emergency and urgent care

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards, which was part of the mandatory training. From the records we noted that 100% of clinicians had completed the training. We viewed the training material for MCA level 2 which was comprehensive.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004, and they knew who to contact for advice. Staff had received training in conflict management and breakaway techniques. They were aware of the limitations in relation to restraint and would refer to the police if necessary for assistance.

Are Emergency and urgent care caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

The inspection team were unable to observe care provided in ambulance vehicles at the time of the inspection, due to the COVID-19 pandemic. This was in place to minimise risks to service users and staff in an enclosed environment.

Staff followed policy to keep patient care and treatment confidential. They ensured the PRF was completed and stored securely in the vehicle in transit and returned to the service at the end of their shift.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs.

Staff spoke professionally and in a caring manner when describing their role and patients they cared for. They told us they interacted with patients in a respectful way. Staff told us they would report any disrespectful or discriminatory behaviour to the clinical manager.

Patients said staff treated them with kindness. We viewed some compliment letters which described staff as “Empathetic, kind, compassionate, polite and professional,” and another read, “Thank you to the paramedic who stayed with us at the hospital, their compassion and empathy were outstanding.”

Notifications sent as part of the services registration requirement following raising a safeguarding referral were documented clearly. They identified staff acted in the best interest of the patient, ensuring they received the most appropriate care. Comments relating to the patient’s family were supportive and ensured the safety of those who remained residing in the patient’s home when the patient was transported to hospital.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Good

Emergency and urgent care

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff spoke with compassion and understanding when relating to patient care. Staff had training on equality and diversity and said they understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff were fully aware of the Equality Act 2010 and protected characteristics.

The registered manager referred to the importance of patient care throughout the inspection. They recognised that COVID-19 had impacted on the welfare of some patients and had reflected this in the safeguarding training.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Recognising that some situations were distressing for staff, the service held debriefing sessions and support for staff when required.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us they explained care and treatment to the patient and those close to them. Patients' belongings were placed in designated bags for safekeeping. Staff limited patient's personal items, including medicines from going with the patient to reduce the possibility of them getting misplaced whilst in hospital.

Staff told us they spoke with patients in a way they could understand, using communication aids where necessary which were available. The registered manager told us they had ordered further multi-language books for staff to use.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We viewed positive feedback comments from patients and their families.

The feedback from the Emergency department was positive. We saw one complimentary letter from the Trust relaying a positive message they received from a patient the crew members transported to hospital. They stated it was a "Great reflection on the high standards we aspire to and achieve and a positive image of Medicare and the culture you generate."

Are Emergency and urgent care responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service worked well with partner organisation both in the public and private sector to plan services that meet the needs of people. The registered manager provided us with examples of how the service had influenced an improved safety culture across all the organisations they worked with.

Good

Emergency and urgent care

Managers planned and organised services, so they met the needs of the local population. Managers worked closely with the NHS Trusts to ensure they had the appropriate staffing level to meet the needs of the local population. The registered manager reviewed the capacity demand levels to ensure they could meet the requirements.

The service had systems to help care for patients in need of additional support or specialist intervention such as social services. Staff could access the on-call facilities for support and guidance from appropriately trained health care professionals. This provided integrated person-centred pathways of care involving other service providers to meet the medical emergency and social needs of patients with complex needs.

The service was in the process of expanding and had innovative plans for the new building location. There were plans to incorporate a training centre and employ staff on a permanent basis. This would provide the service with the ability to tailor training to meet the needs of the local client group.

Managers for the service held contract meetings with their commissioners to discuss key performance data, such as IPC, uniform audit, medicine management, incident reporting, DBS compliance and vehicle cleaning to ensure they were compliant.

The service engaged with other health and social care professionals through referring patients to falls prevention team or social services.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

The individual needs of people at the different care provisions were central to the delivery of tailored services. Staff received training for the different care provisions the service supplied both frontline and events, and the appropriate staffing levels and skill mix for each activity was planned.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Multi-language phrase books were used, and the service could consult the NHS language line when required. There was a proactive approach to understanding the needs and preferences of diverse groups of people including those people with protected characteristics under the Equality Act 2010. Some staff had created their own picture books which they used to communicate with patients, for example people living with dementia.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Through the communication system, staff had access to the relevant professionals who would provide advice.

The staff told us the ambulance vehicles were suitable for carrying children with child harness for safety and for paediatric equipment. To ensure comfort for bariatric patients, the sides of the stretcher trolley could be lowered.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The crew assessed each patient as an individual and where necessary would arrange suitable referrals to their GP, falls clinic or social services for further support.

Good

Emergency and urgent care

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

For NHS calls, the registered manager did not monitor response times as staff responded to emergency calls as they were notified. The registered manager told us they were aware of the location of the crews. The service received the calls through the NHS Trusts and vehicles responded. When not attending a call, the crew positioned their vehicle in an appropriate location to be able to respond promptly. The registered manager told us there had been extended waiting times outside the accident and emergency centres of the Trusts which had caused operational pressures.

When attending events, the service carried out pre-planning and organising the staffing levels ahead to ensure they could meet the contracted requirements. The management reviewed staff availability and arranged staffing levels based on individual skills and profession. The service was experienced in arranging long-standing events such as horse racing and large arena events and prepared teams for the event seasons.

The registered manager maintained a capacity demand level matrix with details on how to manage demands using a RAG (red-amber-green) rating to ensure they had enough vehicles and staff to cover the needs of the NHS Trusts.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives, and carers knew how to complain or raise concerns. The service's website clearly showed contact details of the service both telephone and email address. The website had a specific link for patient feedback with a list of questions and a free text space for comments. The registered manager told us that patients sometimes completed the link, sent an email, or would feedback directly to staff, who then informed management. The registered manager told us that sometimes a complaint may be made to the NHS who relayed it to the service.

Staff understood the policy on complaints and knew how to handle them. The service had a comprehensive management of complaints policy and procedure. Staff understood the policy on complaints and knew how to handle them. The staff told us the management team were approachable and would contact them with any concerns.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were audited monthly and discussed at management meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. The registered manager gave us an example of a recent complaint where a staff member had assumed that a particular service would be available at the hospital for the patient, however the patient's expectations were not met. The registered manager shared learning on a one to one with the staff member.

Are Emergency and urgent care well-led?

Good

Emergency and urgent care

Outstanding ☆

We rated well-led as outstanding.

Leadership

Leaders had the skills and abilities to run the service and demonstrated an inclusive, collaborative leadership style. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They actively encouraged staff to develop their skills and take on more senior roles.

The service had an organisation framework highlighting a strong tiered management team. Each part of the service was managed by named operations personnel who oversaw their department with clear management lines and effective leadership at all levels. The service had clinical advisers including a registered medical doctor and pharmacist for key oversight roles.

Staff demonstrated a collaborative leadership style across their service and focused on making a difference to people who used health and social care in England. There was compassionate, inclusive and effective leadership and staff at all levels which demonstrated high levels of experience and capability to deliver excellent care.

The senior leadership team inspired staff in the improvement of patient care, and they had developed strategies to meet the skills gaps within the service and the wider health and care system. The registered manager was exceptionally informed, with an in-depth knowledge about the service and held relevant clinical and management qualifications. The management team had a good working relationship and were supportive of each other. The CEO and registered manager were complimentary of the management team and the staff.

Staff told us that they had been inspired by the leadership team to undertake further learning and constantly strived to improve their clinical knowledge and the care they provided to their patients.

There was an embedded system of leadership development and staff in management roles which followed an internal leadership programme. Four clinical managers directly supported their team of staff. They told us they observed staff competency and mentored staff on the Newly Qualified Paramedic Programme and staff newly employed by the service. The clinical managers worked closely together and although they are allocated a staff team, staff told us they can approach any clinical manager.

Staff told us they felt the authority gradient was appropriate and they could approach any manager and said they were always treated with dignity and respect. Staff were complimentary about the management team and said they were supported in their career development.

The service had regular executive meetings where they discussed the service's performance and feedback from the departmental audits. The registered manager had informed oversight of the service and was present, accessible, and led by example.

Managers worked collaboratively with partner organisation and had influenced positive changes in safety within these working relationships. These included changes to medicines processes and the conveyance of critically injured patients to regional trauma centres.

Good

Emergency and urgent care

The service had a business continuity plan and a well-structured management team who were appropriately qualified and experienced to enable continuation of the service in the event of an unexpected occurrence. The CEO and registered manager understood issues and challenges in the service and had diversified during the COVID-19 pandemic to frontline ambulance support with two local NHS Trusts which ensured sustainability of the business.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on patient care, sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress and were motivated to drive improvement.

The CEO and registered manager produced a presentation about the service at the onset of the inspection. This clearly showed the management team had an in-depth knowledge of the service and the future vision and ambition.

They explained the incoming digital solutions system which were being integrated into the service. To ensure the new systems were embedded, they were running the previous system alongside for a trial period to enable any issues to be identified. Future plans were staggered, providing an integrated approach to ensure the service could continue meeting present and future needs and to allow for managed development to embed.

There were plans to move into new premises with more office and fleet space including carparking, in July 2022 once building work concluded. The human resource (HR) department were organising the employment process for clinicians as permanent staff as well as self-employed personnel to meet future contract plans.

Part of the vision and strategy was the expansion of the new accredited academy which would provide inhouse training for staff and external training for personnel from other companies. The provider had engaged with staff and other partner providers to develop the future training strategy. Clinical courses and approved apprenticeship were planned to commence in September 2022. The academy had a skills laboratory on site to enable students to develop their practical skills before treating patients. The skills laboratory would also provide an area for simulation training for qualified staff. Managers told us that the development of the academy dove tails with staff feedback about their training needs.

The provider was committed to delivering patient-centred focused care and the service introduced the trauma network standards to horse racing and strived to improve patient safety and patient outcomes across the industry.

During the COVID-19 pandemic when the government had restricted events the service looked at innovative ways they could diversify into other areas. The service had experience in attending events such as horse racing that required emergency care response and had staff who were highly trained in attending to emergency and traumatic incidents. Using the management organisational knowledge, clinical staff skills and equipment attending to emergency situations, the service obtained a contract with two NHS Trusts for delivering emergency response. This foresight had allowed the company to continue and grow during the difficult years of the COVID-19 pandemic.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care and were able to influence improvements in patient care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders had a strong focus on safety culture and inspired stakeholders to drive improvement.

Good

Emergency and urgent care

The service had developed a culture focused on safety and high-quality care. Staff reported working in a supportive environment and were encouraged to learn from safety incidents that happened within the organisation and externally without any fear of blame. Managers shared new ways of working with partner organisations to improve standards across health and care services and demonstrated they had influenced policy changes both nationally and locally.

Staff told us there was a transparent working relationship with the clinical managers and they were confident to escalate any issue or concern without fear of repercussions. They were aware of the whistle blowing policy.

The registered manager told us they had an open culture and staff could raise concerns or ideas and staff said they felt listened to. Staff confirmed they were confident to raise complaints, concerns, or safeguarding alerts to the management team. The staff said that when they were on a call, guidance and support was always available. Staff told us they felt valued and part of the team.

Staff had a communication recognised social mobile phone group where they could raise non-confidential questions which provided peer support as well as senior support.

Staff bulletins were sent periodically. Staff were motivated to provide effective patient care and told us “This was the best place they had worked, great sense of loyalty, trust and good working relationships.” They said it was an enjoyable working environment. We observed positive communication between staff members and management during the inspection. During our conversations with staff and management, patient care was referred to frequently. The service promoted a culture of mutual respect between management and staff with patient care being at the core of the service provision.

Governance

Leaders operated very effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Service leaders had ensured governance processes supported the safe and effective delivery of services to their community.

Management and staff were clear about their roles, responsibilities, and accountabilities. The clear management structure ensured all departments had senior personnel oversight, and regular meetings were held with the registered manager to ensure they were fully conversant with the operational management of the service.

Managers worked with partner organisations to improve safety and quality and they had influenced changes to safety and quality in both private and public sector provider organisations.

We spoke with representatives from the human resource (HR) department, and they were knowledgeable and fully understood safe recruitment. We viewed staff files which were well maintained and contained all the relevant employment documents which ensured safe recruitment practices. The HR department conducted weekly audits on the recruitment process.

The CEO told us they were exceptionally proud of working within the team. They recognised financial and commercial challenges and were continually exploring organisation development, which included the new training academy.

The service had a meeting planner which identified which meetings were held weekly and monthly. Those meetings included group safety review, group capacity review, HR and safer recruitment, operational managers, and senior leadership team meetings.

The registered manager held a capacity review every Monday to monitor staff capacity and prepare for the coming week.

Executive meetings were held monthly to discuss quality performance and any changes in practice.

The service had invested in technologies and were incorporating more digital systems in their new premises to ensure the service had a safe and effective working practice to continue to provide high quality patient care.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. Leaders designed and implemented innovative ways of working to ensure their service was as efficient and effective as possible. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risk assessments were completed for all areas of service and reviewed regularly. Separate risk assessments for frontline and event staff were conducted in line with good practice. Staff received training for each line of duty. Regular clinical updates were provided to staff to ensure their practice remained current.

COVID-19 risk assessment and guidance using the RAG (red-amber-green) and potential contact guidelines were in place and being followed. The racecourse event attendance required a specific COVID-19 procedure relating to lateral flow testing (LFT) and there was specific guidance for staff.

We saw risk assessments and compliance audits for display screen equipment and office safety. Audits were undertaken on the cleanliness reflecting on the IPC colour coding and safety of the different areas of the building including the kitchen, internal and external areas, and staff toilets/changing rooms. Daily audits were completed for clinical waste, patient record form (PRF), safeguarding, drug administration and patient falls.

We viewed records relating to electrical equipment, fire and safety and they were compliant. Weekly controlled drug (CD) medicines audits were completed, and they showed no errors. The service conducted monthly site inspections and reviewed incidents and complaints.

Staff completed clinical supervision and hand hygiene audits every four to six weeks. Staff told us they were able to raise any concerns or ideas. The registered manager told us staff raised concerns about one aspect of an external provider's care practice and the service followed it up which highlighted the service listened to staff and acted.

The service recognised the amendment to the Road Traffic Regulations Act 2006 regarding driving under emergency conditions which was due to come into force in April 2022. The service had qualified trainers employed who were undertaking driving updates with staff to ensure they would be compliant by end of April 2022.

Information Management

The service collected reliable data and consistently analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a reliable data collection system and conducted regular audits which were analysed and reviewed to improve practice. The registered manager said they were currently working on increasing the computerised systems to reduce paper documents and to provide a recording system that was secure and efficient.

The service used a comprehensive approach to integrate their information management processes. Data gathered about service performance was shared with staff through the allocated whiteboard. Regular training and supervisions provided opportunities to share information.

Staff had access to paper copies of PRF to enable ease of recording when caring for patients and the information was kept in a secure place when not being used. Paper checklists were also used for checking the vehicles before deployment and they were scanned and recorded within the digital system.

Staff had access to policies and procedures as well as clinical updates about changes to ensure their practice was current.

Safeguarding alerts were raised to the relevant NHS Trust. Electronically generated incident reports were made as required in relation to incidents. The computerised systems the service had in place had various levels of accessibility depending on the role of the staff member. This ensured access to confidential records was on a need-to-know basis.

Engagement

Leaders and staff proactively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service worked closely with private event providers and NHS trusts for frontline services. The service had regular communication with their commissioners and raised opportunities for improved working as well as monitoring safeguarding concerns, patient feedback and monthly checks by the NHS for paramedic registrations.

The registered manager had regular dialogue with the Trusts and had been instrumental in changes to local processes for safeguarding and welfare referrals. This had resulted in patients receiving more timely welfare interventions.

Staff had regular contact with the clinical support line with the Trust, paramedics, registered mental health nurses, registered nurses, on-call doctor and staff at the accident and emergency departments.

Management actively engaged with patients through responding to emails and feedback forms. Management recognised excellent staff practice and wrote to staff personally to thank them.

One letter was from a health professional who stated they were very impressed with how the staff member conducted themselves with their “Engaging behaviour and warmth.” The registered manager acknowledged all compliments with a written response to thank people for taking the time to share their comments. Recognition of compliments were shared with the staff member through written feedback letters.

Service leaders were respected across the horse racing industry and proactively worked with stakeholders to improve safety for riders. The service had introduced the trauma network standards to ensure jockeys received the best quality outcomes following a traumatic injury.

Good

Emergency and urgent care

Learning, continuous improvement and innovation

Service leaders were passionate about improvement and innovation and embedded this in their ways of working. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged and inspired innovation and participation in research.

The service had developed an accredited academy to train staff from the organisation and partner organisations. The new premises were due to open in July 2022 and included a skills laboratory to provide students with an immersive learning environment. The provider had given opportunities for staff to complete apprenticeships and had offered places to partner NHS services. By supporting staff in partner agencies, the service were aiming to reduce the skills shortage in emergency and ambulance care.

We viewed training material for courses provided by the service, and they were of a high standard being comprehensive and informative. Courses included major trauma and conflict management and breakaway training. The registered manager told us they were preparing more in-depth training on dementia to meet the needs of their community.

The service promoted a culture of continued professional development for staff. Some staff told us they appreciated the flexibility of working for the service as they were able to undertake post graduate courses, and management supported flexible working in order to achieve their qualification. Staff told us they were encouraged and inspired to continue their professional development and felt supported to do so.

There were internal career development opportunities for staff, and we spoke to staff who had progressed their career within the organisation taking on different responsibilities.

The service developed and shared new ways of working, including best practice for the management and administration of medicines, with partner organisations. Service leaders felt a responsibility to share good practice to ensure patient safety was improved.

Staff had regular clinical supervision with their line manager which provided opportunities to raise any concerns and to discuss any training needs. Staff participated in regular simulation training both for frontline NHS emergencies and specialist care including managing complex trauma.

The service had registered with an accredited company to provide training courses including apprenticeship and emergency response driving (blue light) courses. The service planned to provide training for their own staff and to expand as a training centre providing courses for external candidates.

The service produced clinical updates which provided current guidance for staff on clinical care practices. Electrocardiogram (ECG) guidance and fracture management procedures were accessible to staff to provide consistency in practice. Because each Trust had their own expectations of care practice, informative Medicare EMS Clinical Update letters were provided on a variety of subjects to ensure staff were fully conversant with the procedures.